KANSAS DEPARTMENT ON AGING

Health and Welfare/ Need for Care

Physician Statement

(Optional)

The Medicaid Home and Community Based Services for the Frail Elderly (HCBS/FE) Plan of Care for _____ includes Attendant Care Services in excess of 40 hour per week.

❑ Upon reviewing the attached documents, **I agree** that the customer requires over 40 hours of Attendant Care Services per week and the customer can be cared for safely in his/her home (least restrictive environment) with the services indicated.

OR

❑ Upon reviewing the attached documents, **I do not agree that 40+ hours of Attendant Care Services are appropriate for the following reason(s):**

- ❑ The proposed 40+ hours of Attendant Care Services are in excess of the customer's needs.
- ❑ The proposed 40+ hours of Attendant Care Services will not allow for the customer to be cared for safely in his/her home.
- ❑ The customer is unable to safely direct his/her care.
- ❑ Other (please explain):_____
  _____
  _____
  _____

Physician Signature: _____ Date: _____

Physician Name: _____
(printed or typed)

Physician Address: _____
_____

Physician Phone: _____

The following documents are attached for the physician's review:

❑ Plan of Care
❑ Customer Service Worksheet
❑ Cost Cap Exception Request